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Making New Jersey a Model for Patient Safety

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Pennsylvania Reporting Landscape

- Pennsylvania has three reporting systems
  - PA Health Care Cost Containment Council (PHC4) Data
  - Chapter 51 Data
  - Patient Safety Data
- All developed for different reasons
- All developed at different times
- All collect different data
- All are being used to further patient safety

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PHC 4

- Created in response to growing health care costs
- Collect over 2 million inpatient discharge records each year
- Act 14 of 2003 renewed PHC4 until 2008
- Act 14 changed makeup of Council and reduced reporting requirements to 35 specific diseases

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PHC4 Inpatient Discharge Data

- 998.2 Accidental puncture or laceration during a procedure
- 998.4 Foreign body accidentally left during a procedure
- 998.7 Acute reaction to foreign substance accidentally left during a procedure
- E870 Accidental cut, puncture, perforation or hemorrhage during medical procedure
- E871 Foreign object left in body during procedure
- E872 Failure of sterile precautions during procedure
- E874 Mechanical failure of instrument or apparatus during procedure
- E875 Contamination or infected blood, other fluid, drug or biological substance
- E876 Other and unspecified misadventures during medical care

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Department of Health Chapter 51

- Developed in 1997 as response to Sunset of CON
- Applies to Licensed Facilities
- Notice of
  - Regulatory Non-compliance
  - Compromise Quality Assurance
  - Compromise Patient Safety
- Identification of Personnel
- Confidentiality of Submitted Reports

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Department of Health Chapter 51

- **Implementation Issues**
  - Definitions
  - Reporting Technologies
  - Data Validity
  - Understanding Value and Use of Data

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DRAFT
Chapter 51 Hospital Data

	1997	1998	1999	2000	2001	2002
Total Incidents	14	39	136	922	2,268	8,884
Total Complaints		1	26	324	552	760
Total Incidents/Complaints	**14**	**40**	**162**	**1,246**	**2,820**	**9,644**

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Patient Safety Authority

- Result of Confluence of 3 issues:
  - Malpractice Insurance Crisis
  - Patient Safety Concerns
  - Elimination of Catastrophic Loss Fund
- Modeled after Aviation System
  - Near Misses to PSA
  - Serious Events to Department of Health
- Membership Replicates Political Landscape
- Includes doctors, hospitals, trial lawyers, patient representatives
- Often Difficult to Reach Consensus

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Patient Safety Authority

- Facility Patient Safety Officer
- Facility Patient Safety Committee
- Licensing Fee Surcharge
- Date Reporting and Patient Safety Plans
- Written Notification to Adversely Affected Patient(s)
- Insurance Discounts

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Lessons Learned

- What data should be reported
- What technology will be used
- What will you do with the data
- Who will get the data at what level of aggregation
- Do not overlook using existing data sets in different ways
- Strive for “good enough” not perfection
- Providers, like governments, resist reporting